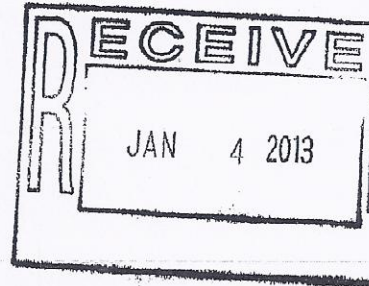


BEFORE THE NEW MEXICO MEDICAL BOARD



IN THE MATTER OF

SHELLY SELLA, M.D.
License No. MD2009-0759,

Respondent.

No. 2012-026

FINDINGS OF FACT
AND CONCLUSIONS OF LAW

This matter came before the State of New Mexico Medical Board ("the Board") on November 29 and 30, 2012 at the New Mexico Medical Society for a hearing before the Hearing Officer David Thomson, Esq., who conducted the hearing on behalf of the Board and who will make his report and recommendation to the Board. The within findings and conclusions shall constitute the Hearing Officer's Report and Recommendation.

The Board was represented at the hearing by Administrative Prosecutor, Daniel Rubin. The Respondent, Dr. Shelley Sella, was represented by Joseph Goldberg and Molly Schmidt-Nowara.

The Hearing Officer heard from four witnesses and admitted seventeen exhibits into evidence.

PROPOSED FINDINGS OF FACT

Proposed Finding

Supporting Record

Finding 1:

Respondent Dr. Shelley Sella is a highly trained medical doctor, Board certified in Obstetrics and Gynecology. Since 2000, Dr. Sella has dedicated her practice exclusively to the provision of abortion services. (Sella Tr. Day 2 at 8). Dr. Sella currently practices medicine at the Southwestern Women's Options Clinic (SWOC) in Albuquerque, New Mexico and provides first through third trimester abortions.

Tr. Day 2 at 6-8

Finding 2:

The New Mexico Medical Board (Medical Board) issued a Notice of Contemplated Action (NCA) against Dr. Sella on August 17, 2012, alleging gross negligence with regard to the treatment of a single patient, M.L. The NCA was issued after a complaint was generated by anti-abortion activists, not the patient or another medical professional. Dr. Sella timely appealed the Board's issuance of the NCA. The NCA was issued after the Board received a recommendation from the Complaint Committee, which relied on staff who had relied on Dr. Bullock's report in making their recommendation whether to issue an NCA. (Sella Tr. Day 1 at 196).

Tr. Day 1 at 196. The Medical Board received an erroneous analysis of the medical records from its expert, Dr. Gerald Bullock

Finding 3:

Dr. Sella has performed approximately ten thousand (10,000) abortions over the course of her career. Dr. Sella has performed between five hundred (500) and one thousand (1000) third trimester abortions. Out of those third trimester abortions, approximately seventy-five (75) patients had had prior C-sections.

Tr. Day 1 at 27.

Finding 4:

Prior to her work at SWOC, Dr. Sella worked for nine years with Dr. George Tiller in Wichita, Kansas. Dr. Tiller was considered one of the leading practitioners in the world for abortions services, including third trimester abortions.

Dr. Sella learned from Dr. Tiller the protocol she consistently has employed with respect to third trimester abortion procedures and employed with patient M.L.. Dr. Tiller was assassinated by gunshot in 2009.

Finding 5:

SWOC is a non-hospital based clinic that provides exemplary care, providing first through third trimester abortions. At the time of M.L.'s care, Dr. Sella alternated with Dr. Susan Robinson in providing medical abortion services at SWOC. SWOC also employs registered nurses, counselors, medical assistants, administrators, and a clinic manager on site at the clinic.

Tr. Day 2 at 8-10, 14, 26-27, 51.

Dr. Philip Darney, Respondent's expert testified that he visited SWOC in connection with establishing a fellowship program at the UNM Medical School and found the level of care there to be "exemplary." Dr. Darney concluded that SWOC would provide good training for the fellowship students. Tr. Day 1 at 110-111. For other facts asserted as to clinic staffing and facilities, see, Tr. Day 2 at 35-36.

Finding 6:

SWOC employs an established transfer procedure in the unusual occurrence that a complication occurs during a patient's care at SWOC. If the patient needs to be transferred to a hospital, the clinic staff calls 911 to have the patient transported by ambulance to the University of New Mexico Health Sciences Center (UNMHSC) and immediately contacts the clinic's back-up physicians who are on staff at UNMHSC. The ambulance responds within minutes. Dr. Sella also contacts the patient's referring physician if there is one.

The transfer procedure in cases of complications that cannot be handled at the clinic was described by Dr. Sella at Tr. Day 2 at 53-54. She explained that she calls 911 for ambulance service because it responds faster than private services, even though 911's records are public records available to Operation Rescue that obtains them and uses them to file complaints with the Board. Tr. Day 2 at 53-55. The physicians contacted at UNM Hospital include teachers at the medical school and those on staff at the UNM Hospital abortion clinic. Tr. Day 2 at 57.

Finding 7:

Most large hospitals do not perform third trimester abortions. The UNMHSC's abortion program is in a free-standing clinic and there is no hospital in New Mexico that performs third trimester abortions.

Tr. Day 1 at 116-117. Dr. Darney explained that large hospitals with heterogeneous staffs frequently have staff members opposed to providing these services, while dedicated clinics are able to hire staff that is willing to participate in abortion services, dedicated to this practice, and experienced in providing these specialized medical services.

Finding 8:

First trimester abortions are generally considered abortions up to twelve (12) or fourteen (14) weeks. (Sella Tr. Day 2 at 11). First trimester abortions are one-day procedures that are either surgical or medical. (Sella Tr. Day 2 at 11). Second and third trimester abortions make up a small portion of all abortion procedures, approximately 5% of all pregnancy terminations.

Tr. Day 1 at 108; Tr. Day 2 at 11.

Finding 9:

Second trimester abortions are surgical procedures. Depending on the gestational age of the fetus, the cervix is prepared for one to two days using either Laminaria or Misoprostol, uterine preparatory agents.

Tr. Day 2 at 12; Tr. Day 2 at 13.

Finding 10:

Third trimester abortions are medical procedures, not surgical procedures.

Tr. Day 1 at 162 - 163; Tr. Day 2 at 11-14.

Finding 11:

Third trimester protocol begins with telephone counseling to the patient by clinic staff.

Tr. Day 2 at 14. Dr. Sella explained that the process starts with extensive phone counseling to determine whether the patient even can be seen at the clinic. Even after the patient arrives, counseling continues.

Finding 12:

Ninety percent of third trimester abortions are performed in four non-hospital-based clinics around the United States, including SWOC. The other three outpatient clinics are in Germantown, Maryland, Los Angeles, California, and Boulder, Colorado.

Tr. Day 2 at 9-10, 38-39.

Finding 13:

There are significant obstacles to providing third trimester abortions in a hospital setting that are not present in a clinical setting, including hospital policy, lack of skilled personnel, equipment, access to the appropriate medications, etc. In addition, often nursing staff at hospitals pose an obstacle to the provision of third trimester abortion services because of lack of training or religious or political attitudes towards abortion.

Tr. Day 1 at 115-117.

Finding 14:

The obstacles presented at hospitals are not present at freestanding clinics. The clinics are able to hire staff specializing in these services that want to provide abortion services.

Tr. Day 1 at 117.

Finding 15:

The protocol Dr. Sella employs for third trimester abortions is the same protocol Dr. Tiller used in his Wichita, Kansas clinic and similar to the ones employed by the other third trimester abortion providers.

Tr. Day 2 at 14.

Finding 16:

The third trimester protocol followed by Dr. Sella is a multi-day process in which the fetus is demised using Digoxin and the cervix is prepared for the induction of labor over the course of multiple days using. (Sella Tr. Day 2 at 14).

Tr. Day 2 at 14.

Finding 17:

SWOC employs two criteria to determine whether it can accept a patient for a third trimester abortion: whether there are (a) maternal indications (meaning that the mother's health is in danger) or (b) fetal indications (evidence of a severely damaged fetus). Further, SWOC determines whether there is a risk that it will not be able to complete the procedure at the clinic without the need to transfer the patient to a hospital. SWOC turns down approximately 15 % of patients who meet the first two criterion, but whom the clinic believes it cannot complete the patient's care at the clinic.

Tr. Day 2 at 51-52. Dr. Sella testified that "If I believe that there is a high likelihood that the patient would need to be transferred, then I would not accept her at all." She cited as examples, a morbidly obese woman seeking a third trimester abortion, and a seriously psychologically troubled patient. *Id.* at 52-53.

Finding 18:

Once it is established based on the telephone interviews and counseling that the clinic is capable of treating a patient, and the patient then arrives in person at the clinic, additional counseling is provided by the clinic's trained counselors and the physician, after which the patient signs consent forms.

Tr. Day 2 at 14.

Finding 19:

For third trimester patients, the first day of treatment at the clinic traditionally starts with counseling and the obtaining of informed consent, after which an ultrasound is taken. Digoxin (a medication used to stop the heartbeat of the fetus) is administered to effect fetal demise. The cervical preparation then begins, which includes the administration of Laminaria (seaweed sticks used to help open the cervix) and Misoprostol (a prostaglandin pge 1). In this context, Misoprostol is used as part of the cervical preparation to soften the cervix. This process continues into a second day. The goal in the cervical preparation process is to modify the cervix to ripen it for the induction of labor on the third or fourth day.

Tr. Day 1 at 49-50, Tr. Day 2 at 14. Dr. Sella testified that she followed the procedure developed for third trimester abortions by Dr. Tiller, with whom she had worked in Wichita, Kansas. Tr. Day 2 at 14-15.

Finding 20:

On the third or fourth day induction of labor is started using Misoprostol and Pitocin. Pitocin is a uterine agent that causes contractions and is used to either induce or augment labor.

Tr. Day 2 at 14. Dr. Sella testified that whether induction begins on the third or the fourth day depends on the condition of the cervix and the history of the patient. *Id.*

Finding 21:

If a patient has had a prior C-section, the third trimester protocol is modified slightly. Such patients are counseled as to the somewhat heightened risk of uterine rupture and that it will take a longer time (3 days of cervical preparation versus the normal 2, with induction on the 4th day). Other than these differences, the procedure for third trimester abortions are the same as those developed by Dr. Tiller.

Day 2 at 15-16, 25-26. Dr. Sella also explained that this risk of uterine rupture was somewhat reduced because the patient, M.L., had a low, transverse scar rather than the traditional vertical scar. Tr. Day 2 at 18-19.

Finding 22:

This protocol follows the protocol Dr. Tiller developed. This protocol is the basic protocol followed by the clinicians that perform third trimester abortion services in the country.

Tr. Day 2 at 26. Dr. Darney testified that when they do third trimester abortions at his clinic associated with the San Francisco General Hospital, they also follow the procedure that Dr. Sella used on her patient M.L. Tr. Day 1 at 162-163.

Finding 23:

The patient at issue in this case, M.L., was a 26-year old woman seeking a third trimester abortion. M.L. lived in Brooklyn, New York. M.L. was a fetal indication patient. When she presented at SWOC, she was 35 weeks pregnant. M.L. was referred to SWOC by her maternal fetal medicine physician, Dr. Victor Rosenberg. Dr. Rosenberg referred her to SWOC because there was no hospital or clinic that could treat her in New York.

Tr. Day 1 at 31; Tr. Day 2 at 57-58, 63; Tr. Day 2 at 115; Sella Exhibit 8 at 001-003, 013.

Finding 24:

When the patient was 33 weeks pregnant, she discovered the fetus she was carrying had severe brain abnormalities, including macrocrania megalencephaly, generalized polymicrogyri, sagittal craniostenosis, and frontal bossing. With these brain and cranial defects, the fetus had a very poor prognosis. The abnormalities were discovered first by an ultrasound and then confirmed by an MRI. On the advice of her maternal fetal medicine specialist in New York, Dr. Victor Rosenberg, the patient consulted with a well-known expert pediatric neuroradiologist, Dr. Illan Timor, who confirmed the poor prognosis for the fetus.

Tr. Day 1 at 31-33; Tr. Day 1 at 115; Tr. Day 2 at 57-57, 61-63; Tr. Day 2 at 147; Sella Exhibit 8.

Finding 25:

The MRI results showed that the head was enlarged and that the fetus weighed approximately 5 pounds and 7 ounces at 34 weeks.

Tr. Day 1 at 36.

Finding 26:

When the patient first contacted SWOC, she spoke with a counselor on staff, Molly Mac Serna, and Dr. Susan Robinson, Dr. Sella's colleague who also performs third trimester abortions. Ms. Serna and Dr. Robinson spoke to the patient and the patient's family members and physician multiple times

Tr. Day 1 at 31-33; Tr. Day 2 at 62-63; Sella Exhibit 8. Coordination with the family and the patient's doctors back in New York was so close that even after M.L. presented to the clinic and was accepted as a patient, SWOC ran tests ordered by M.L.'s New York physicians. Tr. Day 2 at 62-63, Sella Exhibit 8.

Finding 27:

Dr. Robinson consulted with Dr. Sella about M.L. The patient also arranged to have information from Dr. Timor and Dr. Rosenberg sent to the clinic.

Tr. Day 1 at 31-32; Sella Exh 8.

Finding 28:

Dr. Robinson conferred with Dr. Sella about the fetus's brain abnormalities, about M.L.'s history, including the prior C-section and Dr. Robinson's conversations with the patient and the patient's family about the patient's prior C-section. Dr. Robinson spoke with the patient and her family about the risks associated with a third trimester abortion after a prior C-section, including uterine rupture.

Tr. Day 1 at 32, Sella Exh 8 at 01-03.

Finding 29:

Uterine rupture is an opening of the uterus. While it is a risk during any delivery, it is an increased risk if the patient has had a prior C-section. M.L. had a low transverse incision from her prior C-section. A low transverse incision is in the lower part of the uterus that develops in the later part of the pregnancy. This type of incision is less susceptible to uterine rupture than the classical incision, which is a vertical incision from the top to bottom of the uterus.

Tr. Day 1 at 74; Tr. Day 1 at 75.

Finding 30:

Based on the substantial information gathered from the patient and her physicians in New York by Dr. Robinson and the clinic staff, Dr. Robinson and Dr. Sella determined that M.L. was a suitable patient for SWOC.

Tr. Day 2 at 62.

Finding 31:

M.L. was an appropriate candidate for a third trimester abortion as a fetal indication patient.

Dr. Sella testified that this was considered an abortion based on a fetal indication (Tr. Day 1 at 59) as did Dr. Darney (Tr. Day 1 at 112-113) and the SWOC records reflect an admission based on fetal indication. Sella Exhibit 8. The Prosecution's expert Dr. Bullock acknowledged that while there was "suspected" indication of an abortion, there was no "medical indication." Dr. Bullock asserted the indication was "not proven" (Tr. Day 1 at 241-42) despite the evidence of the diagnosis based on an MRI done by M.L.'s Maternal Fetal Medicine Specialist Dr. Rosenberg in New York (Sella Exhibit 8 at 009), which diagnosis was confirmed by her widely respected fetal neuroradiologist, Dr. Timor (Sella Exhibit 8 at 02) and the sonogram performed at SWOC after M.L. was admitted. Tr. Day 1 at 152.

Finding 32:

The patient arrived at SWOC on May 10, 2011. The patient presented at the clinic with her mother and husband. Dr. Sella's plan was to effect fetal demise, then prepare the cervix for three days and, finally, induce labor on the fourth day.

Tr. Day 1 at 33, 65.

Finding 33:

When the patient first presented to the clinic, she filled out paperwork (including consent forms). Dr. Sella met with her and conducted an examination before having an ultrasound performed. In addition SWOC performed tests (amniocentesis and fetal blood draw) requested by M.L.'s doctors in New York.

Sella Exhibit 8, Tr. Day 2 at 62-63.

Finding 34:

The patient was adequately informed of the risk of uterine rupture.

The Prosecution's expert Dr. Bullock voiced no objection to the consent, and opined that it was adequate. Tr. Day 1 at 213. He did not cite the inadequacy of the consent as grounds for his opinion that Dr. Sella fell beneath the Standard of Care in treating M.L. Tr. Day 1 at 244-245. In the end, the prosecutor and defense counsel stipulated that adequacy of the consent (including counseling of the patient on the elevated risk of uterine rupture) was not an issue. Tr. Day 1 at 263.

Finding 35:

After her examination of the patient, the taking of vital signs, and the patient's ultrasound, Dr. Sella began the first procedure, which was to get fetal blood draw and amniocentesis samples that had been requested by Dr. Rosenberg, M.L.'s maternal fetal medicine physician in New York.

Tr. Day 2 at 62-63; Sella Exhibit 8 at 06-08.

Finding 36:

Dr. Sella then injected Digoxin to effect fetal demise. Dr. Sella then began preparing the cervix by inserting Laminaria. Dr. Sella then vaginally administered 100 micrograms (mcg) of Misoprostol to help shorten the cervix to prepare it for the induction of labor. This was the last procedure done on the first day of treatment. The patient was discharged from the clinic and was instructed to return the next morning.

Tr. Day 1 at 50; Tr. Day 2 at 63-64. The record of Digoxin injection is at Sella Exhibit 8 at 022. M.L.'s consent to the Digoxin to effect fetal demise is at Sella Exhibit 8 at 016.

Finding 37:

On the second day of treatment, the patient arrived at the clinic in the morning. Dr. Sella's original plan was to see the patient just once on the second day of treatment, but after examining the patient, she decided to see the patient again in the afternoon of the second day because Dr. Sella noted that the patient was fairly anxious. Further, Dr. Sella wanted M.L. to have as much cervical dilation as possible when she started to induce labor on the fourth day and she thought that another consultation with her patient to check on the degree of dilation would be beneficial.

Tr. Day 2 at 64-65.

Finding 38:

When Dr. Sella first saw the patient in the morning of day two (May 11, 2011), she performed an ultrasound that confirmed the demise of the fetus. Dr. Sella then removed the Laminaria and checked the patient's cervix. Dr. Sella inserted more Laminaria and administered another 100 mcg dose of Misoprostol vaginally to aid in cervix preparation.

Tr. Day 2 at 65.

Finding 39:

On the morning of day 2, after the ultrasound and examination by Dr. Sella, the patient was discharged and instructed to return to the clinic at approximately 5:00 p.m. the same day. When she was discharged, Dr. Sella gave M.L. 100 mcg of Misoprostol to take buccally between the cheek and jaw at 3:00 p.m., which is Dr. Sella's standard practice for third trimester abortion patients. Dr. Sella advised the patient that if she started contractions, she should not take the 100 mcg dose of Misoprostol given to her to take back to her hotel.

Tr. Day 2 at 65-68; Tr. Day 1 at 60-61. Dr. Sella testified that not only was it her standard practice in third trimester abortions to give the patient Misoprostol to administer at home or away from the clinic, but that she had learned this practice while working with Dr. Tiller, and that to her knowledge, this was standard practice among all physicians who performed third trimester abortions. Tr. Day 2 at 67.

Finding 40:

The patient M.L. returned to the clinic at about 5:00 p.m. the same day (May 11, 2011). Dr. Sella removed the Laminaria and checked her cervix, which had not changed since the morning. The patient's water broke when Dr. Sella inserted more Laminaria. Dr. Sella advised the patient to continue taking the Misoprostol buccally every six hours around the clock with the next dose to be at 9:00 p.m. The patient was discharged with the plan being that Dr. Sella would see her the next day to insert more Laminaria to encourage cervix dilation.

Tr. Day 2 at 68-69.

Finding 41:

The patient M.L. returned for a third time on Day 2 at approximately 10:55p.m.. She was in labor with contractions about every 4 to 5 minutes apart. Dr. Sella removed the Laminaria and checked M.L.'s cervix. The patient had not taken the Misoprostol dose at 9:00 p.m. as she had been instructed by Dr. Sella because she had started having contractions.

Tr. Day 1 at 60-62; Tr. Day 2 at 70;
Sella Exhibit 8 at 030.

Finding 42:

When the patient presented to the clinic in labor, she was admitted to the clinic. Dr. Sella augmented the patient's labor with 100 mcg of Misoprostol administered to the patient at approximately 11:18 p.m. on May 11, 2011. Dr. Sella then administered another dose of Misoprostol approximately at 12:24 a.m. on May 12, 2011. Both doses of Misoprostol were administered buccally and the patient threw up the second dose within half an hour after it was administered. Dr. Sella observed only minimal change in the dilation of M.L.'s cervix.

Tr. Day 1 at 62-63; Tr. Day 2 at 70-71; Sella Exhibit 8 at 030.

Finding 43:

After the patient threw up the 100 mcg dose of Misoprostol at approximately 12:50 a.m. on May 12, 2011, Dr. Sella did not administer any more Misoprostol to M.L.

Tr. Day 2 at 72.

Finding 44:

At the same time Dr. Sella administered a dose of Misoprostol at approximately 12:24 a.m. on May 12, 2011, she started the patient on a low dose of Pitocin, 10 units/1000 ccs, administered intravenously.

Tr. Day 1 at 64-65.

Finding 45:

Until a low dose of Pitocin was administered to M.L. at 12:24 a.m. on the third day (May 12), Dr. Sella had not given M.L. Pitocin.

Dr. Sella testified that she did not give M.L. Pitocin on the first day (May 10). Tr. Day 2 at 63-64. She also testified that she did not give M.L. Pitocin during the first two visits on Day 2 (May 11). Tr. Day 2 at 69.

Finding 46:

The patient had Misoprostol in her mouth at the same time Pitocin was administered for approximately twenty-seven minutes. This was the only time Misoprostol and Pitocin were administered at the same time. The half-life of Misoprostol is approximately 20 to 40 minutes. Accordingly, the Misoprostol was out of the patient's system within three to four hours after it was administered.

Tr. Day 2 at 71-72. Dr. Sella testified that she administered the second dose of Misoprostol during that visit at 00:25 on Day 3 (May 12), and that M.L. vomited the dose at 00:52, some 27 minutes later. After that, Dr. Sella administered no more Misoprostol to her patient M.L. Tr. Day 1 at 70; Tr. Day 2 at 72.

Finding 47:

Because the patient was not progressing with her labor as quickly as expected and had thrown up the last dose of Misoprostol, Dr. Sella changed the treatment plan to place the patient on therapeutic rest in the clinic's gurney room for the remainder of the early morning hours of May 12, 2011. Dr. Sella placed the patient on Versed (a sedative), Fentanyl (a pain medication), and the low dose of Pitocin. Dr. Sella's plan was to allow the patient to rest in the gurney room, where she was continuously monitored by staff, and Dr. Sella planned to reassess the patient's progress in the morning of May 12, 2011.

Tr. Day 1 at 66-68.

Finding 48:

The patient awoke at approximately 7:12 a.m. on May 12, 2011. Dr. Sella examined the patient and determined that the patient was still not in active labor. The patient's cervix had only dilated two centimeters over the course of eight hours. Accordingly, Dr. Sella increased the Pitocin dose to 60 units/1000 ccs to encourage contractions and facilitate labor, per her normal protocol.

Finding 49:

At approximately 1:15 p.m. on May 12, 2011, Dr. Sella brought the patient from the gurney room into a procedure room to examine her, since she had anticipated that the patient would have delivered by that point in time. The examination was to evaluate whether to do a cranial decompression (to collapse the fetus's head) to facilitate delivery. When Dr. Sella examined the patient, Dr. Sella noted that she could no longer feel the head of the fetus, which she previously could. Dr. Sella immediately performed an ultrasound and noted that the fetus was sideways, or transverse. Because of the change in position of the fetus, Dr. Sella strongly suspected uterine rupture. Dr. Sella then changed the treatment plan to discontinue the Pitocin, and to transfer the patient to UNMHSC in order to rule out uterine rupture.

Finding 50:

The patient was transported to UNMHSC very quickly. Dr. Sella had telephonic contact with the providers at UNMHSC confirming that the patient had been accepted at UNMHSC for treatment. The patient was admitted less than a half hour after Dr. Sella noted the probable uterine rupture.

Tr. Day 1 at 69-70; Tr. Day 2 at 72-73. When M.L. awoke shortly after 7:00 a.m. on Day 3, upon examination by Dr. Sella it appeared that her cervix had dilated only about 2 more centimeters (from 5 to 7) and she was not in active labor. Dr. Sella decided to increase the dosage of Pitocin at that time in order to induce labor, as "the safest thing to do." Tr. Day 2 at 73.

Tr. Day 1 at 71-74. Dr. Sella testified that upon being unable to palpate the fetus's head, she suspected a transverse lie and immediately did an ultrasound to confirm her suspicion. She explained that the ultrasound equipment was right there in the procedure room. Tr. Day 1 at 71.

Tr. Day 1 at 77-79. There was a period of 24 minutes between Dr. Sella's examination of M.L. detecting the change in the fetus's position at 1:15 p.m. on May 12, and M.L.'s admission to the UNMHSC at 1:39 p.m. Tr. Day 1 at 78-79.

Finding 51:

After arriving at UNMHSC, the patient's rupture was repaired and blood loss was within normal limits, meaning that she did not have to receive a transfusion.

Tr. Day 1 at 81-82.

Finding 52:

The patient was discharged after three days and returned to New York without incident. Dr. Sella maintained contact with the patient and her family during her stay at UNMHSC.

Tr. Day 1 at 79-80.

Finding 53:

The fetus was not weighed. The best estimate of the weight of the fetus is based on the sonogram from May 2, 2011. On that date, the fetus was estimated to weigh approximately 5 pounds and 7 ounces. A fetus gains approximately a half a pound a week at M.L.'s stage of pregnancy. Based on the sonogram and the generally accepted understanding of weight gain of a fetus of this gestational age, the fetus was approximately 5 pounds and 13 ounces at the time it was delivered at UNMHSC.

Tr. Day 1 at 92 - 94; Sella Exhibit 8 at 009.

Finding 54:

Once Digoxin is administered and fetal demise is effected, the tissue of the fetus begins to soften and the maximum diameter and compliance of the fetal head is decreased by a considerable difference. The softening of the fetal head as the result of fetal demise was clinically significant at the time of delivery, three days after the administration of Digoxin and fetal demise.

Tr. Day 1 at 168 - 171.

Finding 55:

The Prosecutor called two witnesses in his case, Dr. Sella and an expert witness, Dr. Gerald Bullock. Dr. Bullock is an obstetrician/gynecologist from Houston, Texas. Although Dr. Bullock has extensive experience in live birth, he is not an expert in the provision of abortion services. Over his career, he has handled at most three abortions a year. He has not performed any third trimester abortions.

Tr. Day 1 at 198, 201. Dr. Sella estimated that she had performed approximately 10,000 abortions during her medical career, including between 500 and 1000 third trimester abortions. Tr. Day 1 at 26-27. By way of contrast, Dr. Bullock estimated that he had performed about 10,000 live births and that he had performed perhaps 2-3 abortions a year, but never a medical third trimester abortion. Tr. Day 1 at 199, 201. Respondent's expert, Dr. Darney, testified that he has been performing abortions, including third trimester abortions, since 1973.

Finding 56:

Dr. Bullock reviewed the medical records in this case and rendered a written opinion to the Board before the NCA was issued in this case. Dr. Bullock's written report had numerous factual errors in it, including but not limited to, miscalculations of the dosages and combinations of medications that Dr. Sella administered to M.L. and the erroneous belief that Dr. Sella and the staff at SWOC did not take the patient's vital signs. For example, Dr. Bullock erroneously opined in his report that Dr. Sella began administering Misoprostol and Pitocin simultaneously on Day 1 of the patient's treatment. As stated above in paragraphs 44 through 46, this is incorrect.

Finding 57:

Dr. Sella and the staff at SWOC consistently monitored the patient's vital signs throughout her treatment at SWOC.

Finding 58:

Dr. Bullock's testimony at the hearing was inconsistent with his written report. Dr. Bullock stated in his report that his "assumption from the record is that [M.L.] was receiving the 50 milliunits per minute [of Pitocin] during all the times she was also receiving Misoprostol." This assumption was incorrect.

Sella Exhibit 12 is Dr. Bullock's Report. At hearing, Dr. Bullock, backed off many of the statements in his report that formed the basis of his opinion that Dr. Sella had fallen beneath the standard of care in treating M.L. He testified that he only realized for the first time at hearing that Dr. Sella went to M.L. on the afternoon of Day 3 (May 12) for the purpose of collapsing the fetal head and delivering the fetus. Tr. Day 1 at 220-221. Similarly, he acknowledged that the rupture was "fortuitous" and could not have been predicted. Tr. Day at 221. He also claimed that he had never asserted that Dr. Sella had fallen beneath the standard of care because of the fetal head size. Tr. Day 1 at 226-228. And although his report asserted that M.L. had been given Pitocin continuously throughout the three days, the evidence was that Pitocin was administered only on the third day. Dr. Bullock simply denied, the language of his report notwithstanding, that he had ever thought otherwise. Tr. Day 1, 226 228; 231-235.

Sella Exhibit 8.

Tr. Day 1 at 226-228; 231-235.

Finding 59:

Dr. Bullock also testified at his deposition before the hearing that he believed that M.L. was receiving Pitocin and Misoprostol at the same time. Dr. Bullock, however, testified at the hearing that he "not at any time thought the patient got Pitocin on the first day." Dr. Bullock was unable to explain the discrepancies between his written report, deposition testimony and the testimony he gave at trial.

Finding 60:

Dr. Bullock initially opined that it was not below the standard of care for Dr. Sella to determine that M.L. was an appropriate candidate for a third trimester abortion, but changed his opinion later in his testimony.

Finding 61:

Dr. Bullock ultimately opined in his testimony that Dr. Sella's care of M.L. was grossly negligent because (1) she combined the administration of Pitocin and Misoprostol; (2) she performed the third trimester abortion in a clinic setting; and (3) she sent the patient home with Misoprostol. Dr. Bullock first expressed the third criticism at the hearing, but not before in either his report or deposition.

As noted, when confronted at hearing with the SWOC medical records, despite the language in his Report and his deposition testimony, Dr. Bullock claimed that he never believed that M.L. had been given Pitocin throughout the three day period of her abortion. Tr. Day 1 at 226-228; 231-235.

Tr. Day 1 at 222; 242-243.

Tr. Day 1 at 244-246. As noted, however, Dr. Bullock was wrong in his determination that M.L. was given Pitocin along with Misoprostol throughout the three day period. In actuality, Pitocin was only administered very early on Day 3 and into Day 3 until it became clear to Dr. Sella that the uterus had ruptured. Dr. Bullock's second and third grounds for his opinion that Dr. Sella fell beneath the standard of care was based on his reliance on ACOG Committee Opinion No 342 and Practice Bulletin No. 115, the first of which has been replaced, and the second of which addresses issues related to live births, not abortions.

Finding 62:

Dr. Bullock's testimony at the hearing with regard to the number of doses of Misoprostol administered on Day 1 of the patient's treatment was incorrect. Until he was confronted with the medical records, Dr. Bullock maintained that the patient had received two doses of 100 mcg of Misoprostol on Day 1, when in fact she had only received one dose on Day 1.

Tr. Day 1 at 251-253.

Finding 63:

Dr. Bullock based his opinion on an obstetrical standard of care. In his view, there is no distinction between the standard of care applicable in a third trimester abortion procedure versus a live birth. This is incorrect. The obstetric standard of care is not the appropriate standard of care to apply to third trimester abortions.

Tr. Day 1 at 248. Respondent's expert Dr. Darney explained that Dr. Bullock had based his opinion as to the standard of care that he believed Dr. Sella had violated on the ACOG Bulletins which addressed delivery of a live baby, not to situations attendant to the abortion of an already dead fetus. Tr. Day 1 at 130-131. Dr. Darney explained that Dr. Bullock failed to distinguish between types of care and specialized procedures necessary for the termination of a pregnancy as opposed to a live birth. Tr. Day 1 at 132.

Finding 64:

Dr. Darney explained that there are multiple differences between delivering a live baby and performing a third trimester abortion. The most important difference is the intent to deliver a live, healthy baby. That is the opposite intent in the case of a pregnancy termination. This fundamental difference governs how uterine stimulants (e.g.,

Misoprostol and Pitocin) are used for the purpose of preparing or softening the cervix. For example, in an abortion, a provider is not concerned about the effect of the uterine stimulants over a long period of time on fetal heart rate or otherwise compromising fetal welfare.

Tr. Day 1 at 133-134.

Finding 65:

Dr. Darney explained that there are differences between a live birth and an abortion with respect to the use of uterine stimulants like Pitocin and Misoprostol for the purpose of inducing or augmenting labor. The intent of an abortion is to accomplish cervical dilation in preparation for the speedy evacuation of the uterine contents accompanied by the evacuation of the cerebral contents. It is not comparable to a live birth, where the entire head of the fetus must come through the pelvis. There is also no concern regarding the effects of Pitocin and Misoprostol on placental perfusion and fetal well-being in an abortion procedure where the fetus already is dead.

Tr. Day 1 at 134 - 135.

Finding 66:

Dr. Bullock, as an obstetrician, with vast experience in delivering live babies and little experience in performing abortions (and none in third trimester medical abortions), had no independent knowledge of what abortion providers actually do in third trimester procedures. Dr. Bullock has not visited any abortion clinics. Dr. Bullock has never spoken with Dr. Hern, Dr. Carhart, or Dr. Seletz, the other third trimester abortion providers in the United States.

Tr. Day 1 at 249.

Finding 67:

Dr. Bullock also based his opinion on a misreading of the American College of Obstetrics and Gynecology (ACOG) Bulletin 115. Contrary to Dr. Bullock's understanding of ACOG 115, ACOG 115—which is a guideline, not an expression of the standard of care—does not state that women with prior C-sections should not have a trial of labor after C-section (TOLAC) in a clinic setting. The tenants of ACOG 115 are to accomplish a live birth. ACOG 115 is not directed at abortion procedures.

Tr. Day 1 at 141-146, 204; Tr. Day 2 at 78; Sella Exhibit 10. Both the ACOG Committee Opinion No. 342 (dated August, 2006), entitled "Induction of Labor for Vaginal Birth after Cesarean Section (Sella Exhibit 14) and ACOG Practice Bulletin 115 (dated August, 2010), entitled "Vaginal Birth after Cesarean: New Insights" (Sella Exhibit 10) specifically provide on their front cover that they "should not be construed as dictating an exclusive course of treatment or procedure" Not only are they not directed to abortion practice, but they do not purport to prescribe the standard of care for anything.

Finding 68:

Dr. Bullock also relied an out-of-date ACOG Committee Opinion (ACOG Committee Op. 342, Sella Exhibit 14) to support his opinion about the administration of Pitocin and Misoprostol together.

ACOG Committee Op. 342, Sella Exhibit 14; Tr. Day 1 at 224.

Finding 69:

Dr. Bullock did not reference any literature or other documentary evidence to support his opinion that it violated the standard of care for Dr. Sella to give Misoprostol to the patient to take back with her to the hotel.

Tr. Day 1 at 249 - 250.

Finding 70:

While Dr. Bullock opined that it was important for the clinic to be close to a hospital in case of emergency, he was unaware until the day of the hearing that SWOC was very close to UNMHSC.

Tr. Day 1 at 259.

Finding 71:

Dr. Bullock's opinion was undercut by the expert opinion of Dr. Phillip Darney, who was called by Dr. Sella at the hearing. Dr. Darney is one of the preeminent experts in the area of women's health and abortion services.

Dr. Darney's impressive resume and professional accomplishments are set forth at Tr. Day 1 at 99-109. He testified that he considers himself as having expertise in both gynecological and obstetrical practice and the performance of abortion services. Tr. Day 1 at 109.

Finding 72:

Dr. Darney is a distinguished Professor of Obstetrics, Gynecology and Reproductive Sciences and of Health Policy at the University of California San Francisco. Dr. Darney has been at UCSF since 1981. Dr. Darney achieved the rank of Distinguished Professor through academic achievement, publication, and research grants.

Tr. Day 1 at 98-99.

Finding 73:

UCSF usually is ranked number two among all medical schools in the United States in the area of women's health.

Tr. Day 1 at 99.

Finding 74:

Dr. Darney also has been Chief of Obstetrics and Gynecology at San Francisco General Hospital for 15 years and is the founding director of the Bixby Center for Global Reproductive Health.

Tr. Day 1 at 100; Sella Exhibit 9.

Finding 75:

Dr. Darney has written or co-written five textbooks on ambulatory gynecologic surgery, contraception and women's health. Two of the books are in their 13th and 5th editions, respectively. Dr. Darney has published just short of 200 peer reviewed articles. Dr. Darney was on the editorial board of Obstetrics & Gynecology, the principal journal in the area of obstetrics and gynecology. Dr. Darney has also served as a regular reviewer of articles submitted to the New England Journal of Medicine and Lancet.

Tr. Day 1 at 102-104.

Finding 76:

Dr. Darney has received numerous awards in his career, including being elected in 2003 to the Institute of Medicine of the National Academies, an honor given to only twenty other OB/GYNs.

Tr. Day 1 at 105.

Finding 77:

Dr. Darney is the founder of a fellowship that is a training program for abortion services. Dr. Darney founded the fellowship in 1991 and it has since been expanded to twenty-six other medical schools around the country, including the University of New Mexico in 2010. The fellowship is called the Fellowship in Family Planning and is a recognized fellowship within obstetrics and gynecology. The objective of the fellowship is training in research related to contraception and abortion and clinical skills related to those two fields.

Tr. Day 1 at 107.

Finding 78:

Dr. Darney regularly provides abortion services and has performed approximately ten thousand (10,000) abortions over the course of his practice since 1973.

Tr. Day 1 at 108.

Finding 79:

Dr. Darney has performed third trimester abortions over the course of his practice, including on patients who had had a prior C-section.

Tr. Day 1 at 108 - 109.

Finding 80:

Dr. Darney is an expert in the area of obstetrics and gynecology including the standard of care for providing obstetrical services in patients with prior C-sections (vaginal delivery after Cesarean, or VBAC and trial of labor after Cesarean, or TOLAC).

Tr. Day 1 at 109.

Finding 81:

Dr. Darney is also an expert in the area of providing medical abortion services, including the national standards of care in providing abortion procedures.

Tr. Day 1 at 109.

Finding 82:

The standard of care at SWOC is in general exemplary.

In setting up the fellowship program at the University of New Mexico, Dr. Darney had the opportunity to visit SWOC. His impression, upon that visit was that the clinic provided "exemplary" abortion services. Tr. Day 1 at 111.

Finding 83:

Dr. Sella's treatment of M.L. comported with requisite circumstances applicable to third trimester abortions. The three most important issues with regard to third trimester abortion services are (1) the physical facility where the termination is performed; (2) the training and expertise of the personnel at the facility; and (3) access to emergency services. In this case, the physical facility comported with the standard of care, the personnel available comported with the standard of care, and the transfer relationship with UNMHC comported with the standard of care.

In response to the Hearing Officer's question, Dr. Darney cited these three factors: adequate physical facility for the patient to labor overnight, adequately trained personnel and physicians, and access to a hospital for emergency services as the criteria that distinguished an abortion clinic's ability adequately and properly to affect third trimester abortions. Tr. Day 1 at 193 - 194. Dr. Darney testified that Dr. Sella's treatment of M.L. comported with these criteria and the applicable standard of care. Tr. Day 1 at 113.

Finding 84:

If the standard of care were that no woman with a prior C-section could obtain a third trimester abortion in a stand-alone clinic setting, it would have a significant impact on the ability of those patients to obtain a third trimester abortion.

Tr. Day 2 at 76.

Finding 85:

A survey of non-hospital based birthing centers in New Mexico revealed that VBAC or TOLAC births are regularly done in a non-hospital setting. (Sella Exhibit 16).

Sella Exhibit 16, Tr. Day 2 at 116-123.

Proposed Conclusions of Law

Conclusion of Law 2:

The Board is authorized to conduct this hearing.

NMAC 16.10.6.3, promulgated pursuant to and in accordance with the Medical Practice Act and the Uniform Licensing Act.

Conclusion of Law 3:

The standard of proof to be applied by the Board is by a preponderance of the evidence.

N.M.S.A. 1978 § 61-1-13; *Foster v. Board of Dentistry of State of N.M.*, 103 N.M. 776, 777-78, 714 P.2d 580, 581-82 (1986).

Conclusion of Law 4:

To suspend or revoke Dr. Sella's license to practice medicine, the Board must find that she acted in conscious and deliberate disregard of the interests, safety and well-being of her patient M.L.

NMSA 1978 § 61-6-15(D)(12) provides that "gross negligence" shall be the ground for a finding of unprofessional conduct warranting suspension or revocation of a medical license. The term "gross negligence" has been interpreted in New Mexico law to mean willful and wanton conduct, or the "conscious and deliberate disregard of the interests of others" *Paiz v. State Farm Fire & Cas. Co.*, 118 N.M. 203, 211, 880 P.2d 300 (1994).

The parties agree that the standard is "Willful and wanton" conduct. Tr. Day 1 at 217.

Conclusion of Law 5:

Violation of the applicable standard of care does not, by itself, establish "gross negligence" as defined in New Mexico law.

UJI 13-1827 defines willful conduct as the intentional doing of an act with knowledge that harm may result, and defines wanton conduct as doing an act with utter indifference of a person's rights or safety.

Conclusion of Law 6:

Dr. Sella did not act with conscious or deliberate disregard for the safety of her patient M.L.

There is no evidence on this record that Dr. Sella acted with conscious or deliberate disregard for the safety of her patient M.L.

Conclusion of Law 7:

The Board has failed to demonstrate by a preponderance of the evidence that Dr. Sella was grossly negligent with regard to her care of patient M.L. Dr. Sella was medically justified in performing the procedure and her treatment of patient M.L. was within the established standard of care governing third trimester abortion procedures. The Southwestern Women's Options clinic is a suitable facility for a third trimester abortion under these circumstances. It has adequate staff, adequate facilities, and is closely adjacent to emergency services.

Tr. Day 1 at 113.

Conclusion of Law 8:

Although the uterine rupture suffered by the patient was an unfortunate complication, it was a known risk and was identified and handled by Dr. Sella appropriately.

Both experts and Dr. Sella acknowledged that this was a risk. Tr. Day 1 at 75, 94, 194, 203, 208, 221; Tr. Day 2 at 15-16, 134.

Conclusion of Law 9:

The undersigned Hearing Officer recommends that the Board dismiss the Notice of Contemplated Action issued on August 17, 2012.

Respectfully submitted,

/s/ Joseph Goldberg

Joseph Goldberg

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I certify that a copy of the foregoing
was sent to David Thomson via first
class and electronic mail, and to Daniel
Rubin via first-class mail, this 4th day of
January, 2013:

/s/ Joseph Goldberg

Joseph Goldberg